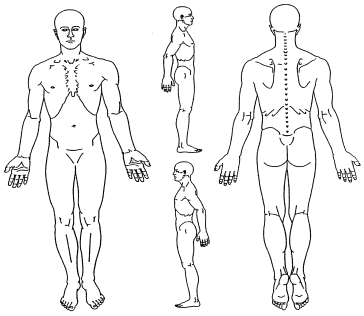
Welcome To Gill Family Chiropractic

Who may we thank for referring you to our office or how did you find us? _____
Have you ever been under chiropractic care before? ❑No ❑Yes. If yes, For what?: _____

PATIENT DATA (Please Print Legibly):

Name _____ Email _____
For general office announcements and promotions ONLY.
Address _____ City _____ State _____ Zip _____
Phone (Cell) _____ (Home) _____
Age _____ Birth Date _____ Sex ❑M ❑F Occupation _____ Hrs worked per week _____
Emergency Contact _____ Relationship _____Phone _____

CURRENT COMPLAINT: ***Mark an X on the picture where you have this pain or discomfort.***



When did your symptom first appear? _____
What caused this or how did you do it? _____
Explain if you felt or had this symptom before? _____
What makes this symptom feel worse? _____
What makes this symptom feel better? _____
Type of pain or discomfort: ❑Sharp ❑Dull ❑Ache ❑Numbness ❑Shooting ❑Tight
❑Burning ❑Tingling ❑Swelling ❑Stabbing ❑Itching ❑Throbbing ❑Other _____

Overall Frequency of complaint: ❑Constant 100% of the time ❑Frequent 75% ❑Intermittent-50% ❑Occasional-25%

Circle the severity of your pain at its BEST and at its WORST.
Use the scale of Zero (no pain) to 10 (severe pain).

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10

How does this symptom affect you at:

Home/Sleep _____ *Work* _____ *Play/Hobby/Sport* _____
Driving/Sitting _____ School _____ Where do you feel your stress _____

FOR WOMEN:

Is there a chance you are Pregnant? ❑No ❑Yes ❑ Not sure! How many weeks? _____
Are you nursing? ❑No ❑Yes
Do you have breast implants? ❑No ❑Yes

HEALTH HISTORY: Please check each of the conditions that you **have now or had in the past**

❑AIDS / HIV	❑Dizziness / Vertigo	❑Loss of Sleep	❑Shingles
❑Allergies	❑Epilepsy	❑Lower Back Problems	❑Shoulder Pain/Tingling
❑Arm Pain/Tingling	❑Feet Pain/Tingling	❑Mid Back Problems	❑Stroke
❑Asthma	❑Hand Pain/Tingling	❑Migraines	❑Tumors/Growths
❑Bleeding Disorders	❑Headaches	❑Multiple Sclerosis	❑Pain that wakes you up at night
❑Cancer	❑Heart Attack/Stroke	❑Neck Pain	
❑Constipation	❑High/Low Blood Pressure	❑Numbness _____	❑Previous Motor Vehicle Accident(s)
❑Depression	❑Herniated Disk	❑Osteoporosis/Osteopenia	
❑Diabetes	❑Irritable Bowel	❑Parkinson's Disease	
❑Digestive Problems	❑Jaw Pain	❑Sciatica	❑Other _____

Injuries/Surgeries you have had:	**Description**	**Date**
Significant Falls	_____	_____
Head Injuries	_____	_____
Broken Bones/Dislocations	_____	_____
Surgeries	_____	_____

Print Name (again please): _____ **Date of Birth (again please):** _____

Lifestyle Habits:

Tobacco (#/day) _____ Coffee (cups/day) _____ Sleep (hrs/day) _____ Water (oz/day) _____
Alcohol (drinks/day) _____ Tea (cups/day) _____ Soft Drinks (cans/day) _____ ❑Diet or ❑Regular

Exercise: Type _____ Frequency _____

_____ _____

Stated Height: _____ **Stated Weight:** _____ [Office Use Only Blood Pressure: _____, Pulse: _____]

FAMILY HISTORY: Please tell us about the major health conditions of your immediate family.

Family Member Relation:	**Health Problem:**
_____	_____
_____	_____

MEDICATIONS TAKEN NOW: List prescription, OTC, vitamins, minerals, herbs & supplements etc.

Name:	**Purpose:**	**How Long Taken?:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHY CHIROPRACTIC?

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

RELIEF CARE

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the probem. Corrective care varies in length of time, but is more lasting.

FINANCIAL AGREEMENT:

You understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and you. You hereby authorize assignment of your insurance rights and benefits (if applicable) directly to Gill Family Chiropractic for services rendered. There may be instances where Gill Family Chiropractic will provide you with a 'Statement of Charges' that you can personally send directly to your insurance company for reimbursement back to you. **You clearly understand and agree that all services rendered to you are charged directly to you and that you are personally and financially responsible for payment whether or not paid by insurance. All payment is due at the time of service.**

_____

Patient (or Guardian) Signature Date of 1st Visit